



State of New Hampshire
The Office of Licensed Allied Health Professionals
2 Industrial Park Drive, Concord NH 03301

SUPERVISION FORM

To be completed by the Governing Board, if applicable

Purpose of supervision: _____

To be checked if supervision is of an Assistant ☐

To be completed by the person to be supervised Please print legibly

Name of person to be supervised _____ License #: _____

Residential and business addresses of person being supervised

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|--|
| Residential address |
| Business mailing address (PO or street address and city, state, zip) |

To be completed by the Supervisor

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|---|
| Name |
| Profession and NH professional license # |
| Business mailing address (PO or street address and city, state, zip) and phone number |

Site of supervision (Location of institution or office or facility)

| |
|---|
| Site name |
| Site location (street, city/town) and phone number |
| Site mailing address |
| Date Supervision started: _____ Date Supervision Completed: _____ |

By signing this form, I state that I have read and understood the applicable rules of supervision or order of the Board for supervision, agree to undertake the duties of supervision set forth in the rules or order of the Board, agree to be responsible for the acts and omissions of any person to whom I delegate the duties of supervision, and acknowledge that my own or my delegate's failure to comply with the rules or order of the Board might result in disciplinary sanctions.

Signature of supervisor
Profession and license number

date

Please note: If there is a change in Supervisors, the new Supervisor should fill out a new copy of this Supervision Form and submit it to the Governing Board. Contact the Office at 603-271-8389 to request the form.